POC #3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445190	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HOUSE, THE	260 BELLEBROOK RD , BRISTOL, TN 37620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and investigation of complaints #40298 and #40649 were conducted at The Cambridge House on 2/16/17 - 3/2/17. Deficiencies were cited from the investigation of #40649 resulting in an Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident) for the facility's failure to provide adequate supervision to prevent unsafe wandering and elopement (when a resident leaves the premises or a safe area without authorization), failure to correct resident's Minimum Data Set (MDS) regarding their wandering, failure to provide Sufficient Nurse Staffing to prevent elopement of residents, and for the Medical Director and Quality Assurance Committee's failure to identify safety hazards. An extended survey was conducted on 3/1/17 - 3/2/17. The Administrator (NHA) was informed of the Immediate Jeopardy in her office on 3/1/17 at 1:25 PM. An Acceptable Allegation of Compliance (AOC), which removed the immediacy of the jeopardy, was received on 3/2/17 at 9:30 AM, and the corrective actions were validated onsite by surveyors on 3/2/17. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. Substandard Quality of Care was cited under F-323 at a scope and severity level of "J".	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nicole Ottaw — LNHA — 3/25/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Noncompliance at F278, F280, F323, F353, F501, and F520 continues at a scope and severity of a "D" level for monitoring of the effectiveness of corrective actions to ensure sustained compliance.	F 000		
F 159 SS=D	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) ...If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)	F 159	1. All current residents whose funds are deposited with the facility will be given written notice that they will have access to their funds 24 hrs a day 7 days a week. This noticewill also be given upon admission. 2. The money will be kept in the Human Resource Office in a metal locked box from 8am to 5 pm Monday through Friday. A metal locked box will be left with the charge nurse on the West Wing from 5 pm to 8am Mondaythrough rFriday and 24 hrs. a day on the weekends 3.There will be a list of residents who havemoney in the account, a log for residents to signout funds taken. The log and money will be checked daily by the BOM Monday through Friday for accuracy. The BOM will replenish the money box and log as needed.	March 24, 2017

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F 159	Continued From page 2 The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide access to resident personal funds after regular business hours and on weekends for 2 residents (#23, #13) of 32	F 159		

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F 159	Continued From page 3 residents with personal funds accounts. The findings included: Medical record review revealed Resident #23 was admitted to the facility on 6/23/16 with diagnoses including Depression, Type 2 Diabetes Mellitus, Hypertension, Community Acquired Pneumonia, Myocardial Infarction, and Acute Hypoxemic Respiratory Failure. Review of the resident's annual Minimum Data Set (MDS) assessment dated 12/27/16 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident was moderately cognitively impaired for daily decision making. Medical record review revealed Resident #13 was admitted to the facility on 6/5/13 with diagnoses including Cerebrovascular Disease, Type 2 Diabetes Mellitus, Hypertension, Anxiety, Heart Failure, History of Falling, Insomnia, Depression and Urinary Tract Infection. Review of the resident's quarterly MDS assessment dated 2/10/17, revealed a BIMS score of 15, indicating the resident was cognitively intact for daily decision making Interview with Resident #23 on 2/27/17 at 12:14 PM, in the resident's room revealed money from Resident #23's personal funds account was not available on weekends. Interview with Resident #13 on 2/27/17 at 3:18 PM, in the resident's room revealed money from Resident #13's personal funds account was not available on weekends and was not available after 5:00 PM on weekdays.	F 159		

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F 159	Continued From page 4 Interview with the Business Office Manager on 3/1/17 at 12:00 PM, in the Business Office Managers Office, confirmed the facility failed to provide access to resident personal funds after regular business hours on weekdays and on weekends.	F 159	**F 278 Assessment Accuracy/Coordination/Certification** 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 58's wandering and elopement risk assessment was updated on January 24, 2017; the resident's MDS was reviewed to ascertain it was correctly coded for the wandering and elopement section and the care plan updated with interventions to mitigate the residents risk for wandering/elopement on March 1, 2017. Resident # 10's wandering and elopement risk assessment was updated on March 1, 2017; the resident's MDS was corrected to reflect the correct wandering and elopement risk and the care plan updated to mitigate that risk on March 21, 2017.	
F 278 SS=J	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278	MDS has been audited quarterly	

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F 278	Continued From page 5 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of Incident/Accident reports, and interviews, the facility failed to accurately assess the wandering risk for two residents (#58, #10) of three residents reviewed with a known risk of wandering and elopement, of 29 residents reviewed. The facility's failure resulted in Resident #58 eloping from the facility, sustaining an open fracture ("If the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") in her right arm requiring surgical repair, and placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office. The findings included: Medical record review revealed Resident #58 was admitted on 6/13/13 with diagnoses including Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, Osteoporosis and Depression.	F 278	2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by this deficient practice. B. The DON ascertained that 100% of current residents wandering assessments were completed by February 19, 2017. The DON will ascertain that the wandering assessment is completed on all residents upon admission, quarterly and with a significant change. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. The licensed nurses were inserviced on February 21, 2017 by the Director of Nursing on the facility's policy for accurate completion of the wandering and elopement risk assessment.	March 24, 2017

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F 278	Continued From page 6 Medical record review of an annual Minimum Data Set (MDS) assessment for Resident #58, dated 2/8/16, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating Resident #58 had a severe cognitive impairment. Further review revealed "... Wandering - Presence & Frequency...Behaviors not exhibited..." (Per the MDS 3.0 Manual, wandering is the act of moving from place to place with or without a specific course or known direction. The wandering resident may be oblivious to his or her physical or safety needs.) Review of a facility Incident/Accident Report dated 2/23/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the facility and was confused. Medical record review of the Wandering and Elopement Assessment dated 2/23/16 revealed Resident #58 was assessed as a wandering and elopement risk. Review of a facility Incident/Accident Report dated 3/16/16 revealed Resident #58 had eloped from the facility at 8:45 PM. Resident #58 was found outside the front doors in the parking lot and was confused. Medical record review of the MDS assessment dated 1/25/16 revealed Resident #58 had severe cognitive impairment and "... Wandering - Presence & Frequency...Behaviors not exhibited..." Review of a facility Incident/Accident Report dated 5/10/16 revealed Resident #58 had eloped from the facility at 4:10 PM. Resident #58 was	F 278	C. The MDSC and interdisciplinary team were in-serviced March 1, 2017 on the need to provide an accurate MDS by reviewing the residents medical record, assessing the resident, interviewing the residents direct care givers and reviewing the RAI manual definitions before coding the MDS. D. The wandering and elopement risk assessments for all current residents were reviewed by the DON and/or designee and all residents identified as an elopement risk had their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers; interventions to minimize the resident's wandering/elopement behavior and interventions to mitigate their individual elopement risk factors by March 1, 2017. The wandering and elopement risk assessments for all residents will continue to be	

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F 278	Continued From page 7 found outside the facility by the 500 hallway exit door and had intermittent confusion. Review of a Psychiatric visit note dated 6/30/16, revealed one of the chief complaints for the visit was Resident #68's "exit seeking" behaviors. Medical record review of a quarterly MDS assessment dated 7/8/16, revealed Resident #68 had severe cognitive impairment and "...Wandering - Presence & Frequency...Behaviors not exhibited..." Medical record review of an Activity Progress Note dated 7/14/16 revealed "...She likes to go outside a lot + [and] frequently seeks ways to get outside..." Review of a Psychiatric visit note dated 7/19/16, revealed one of the chief complaints for the visit was "exit seeking" behaviors. Continued review revealed the resident "...continues with wandering..." Medical record review of a quarterly MDS assessment dated 9/27/16, revealed Resident #68 had severe cognitive impairment and "...Wandering - Presence & Frequency...Behaviors not exhibited..." Medical record review of an annual MDS assessment dated 12/14/16 revealed the resident had severe cognitive impairment and "...Wandering - Presence & Frequency...Behaviors not exhibited..." Review of a facility Incident/Accident Report dated 1/17/17 revealed Resident #68 had eloped from the facility at 9:00 PM. Resident #68 was	F 278	reviewed by a licensed nurse and all residents identified as an elopement risk will have their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers; interventions to minimize the resident's wandering/elopement behavior; and interventions to mitigate their individual elopement risk factors. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. The Director of Nursing or designee will audit 3 recently completed MDS's each week for 10 weeks and then monthly for 3 months to ensure that each section of the MDS has been coded correctly. B. The results of this audit will be reviewed by QAPI committee monthly to determine effectiveness of corrections made and need for further recommendations	March 24, 2017

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F 278	Continued From page 8 found outside the 400 hallway exit. Review of the resident was found lying outside on her stomach with her wheelchair beside her and had abrasions to her face and a swollen wrist. Medical record review of hospital records revealed the resident was transported to the hospital on 1/17/17 and had a surgical repair for an open right wrist fracture. Medical record review of a 14 day MDS assessment dated 2/8/17 revealed Resident #58 had severe cognitive impairment and "...Wandering - Presence & Frequency...Behaviors not exhibited..." Observation of Resident #58 on 2/16/17 at 10:00 AM, revealed the resident in her wheelchair, using her feet and left hand to move the wheelchair around the facility, with no end destination. Interview with Social Worker #1 on 2/16/17 at 10:30 AM, in the conference room, revealed Resident #58 did exhibit exit seeking behaviors and "...had eloped from the facility before..." Interview with Licensed Practical Nurse (LPN) #4 on 2/16/17 at 12:45 PM, in the conference room, revealed Resident #58 "...still wanders over the building..." Observation of Resident #58 on 2/16/17 between 10:00 AM and 1:30 PM, revealed the resident repeatedly propelling the hallways of the facility, except when she was in the dining room for lunch Interview with Social Worker #1 on 2/17/17 at	F 278		

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F 278	Continued From page 9 9:15 AM, in the conference room, confirmed the MDS assessments for Resident #58 did not accurately reflect the resident's wandering status. Interview with the Administrator and Director of Nursing (DON) on 2/17/17 at 9:55 AM, in the conference room, confirmed the MDS assessments dated 2/0/16, 4/25/16, 7/8/16, 9/27/16, 12/14/16 and 2/6/17 for Resident #58 were inaccurate. Continued interview confirmed Resident #58 displayed wandering behaviors daily. Medical record review revealed Resident #10 was admitted on 1/1/11 with diagnoses including Diabetes, Cerebrovascular Disease, Dementia, and Chronic Kidney Disease. Medical record review of the annual MDS assessment dated 2/1/17, revealed Resident #10's BIMS was 4 out of a possible 15, showing severe cognitive impairment, and "...Wandering - Presence & Frequency...Behaviors not exhibited..." Medical record review of Resident #10's care plan dated 2/9/17 revealed "...at risk for wandering and elopement r/t [related to] hx [history] of wandering..." Observation of Resident #10 on 2/16/17 at 1:30 PM, revealed the resident was propelling himself around the facility in his wheelchair. Continued observation revealed he would go from his room to the front door, and repeat the process. Interview with LPN #4 on 2/16/17 at 3:00 PM by the 400 hallway exit door revealed Resident #10 propels himself in his wheelchair to the front	F 278		

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F 278	Continued From page 10 entrance and back to his room repeatedly when his wife is not at the facility. Observation on 2/16/17, at various times throughout the day, revealed Resident #10 repeatedly wandered from his room to the front door, when his wife was not present. Interview with Social Worker #1 on 2/17/17 at 9:15 AM, in the conference room, confirmed the MDS assessment for Resident #10 did not accurately reflect the wandering behavior. Interview with the Administrator and Director of Nursing (DON) on 2/17/17 at 9:55 AM, in the conference room, confirmed the MDS assessment dated 2/1/17 for Resident #10 was inaccurate. Continued interview confirmed Resident #10 had been coded as non-wanderer, but displayed wandering behaviors daily. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 3/2/17, and corrective actions were validated through review of documents, observation, and staff interviews. The surveyors verified the allegation of compliance by: 1. Reviewing the facility's in-service records to validate the two MDS Coordinators responsible for development of the MDS's were in-serviced on 3/1/17. 2. Conducted interviews with the two MDS Coordinators on 3/2/17 in the conference room, to determine the level of comprehension gained through the in-service education conducted on	F 278		

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F 278	Continued From page 11 the morning of 3/1/17 regarding correctly coding the MDS's for wandering behaviors of the residents. 3. Reviewing the MDS assessment of all residents (Residents #58, #10, and #68) assessed at risk for wandering and elopement developed on 3/1/17. The review was to ensure the development of a corrected MDS to aid in the development of a Comprehensive Care Plan to prevent unsafe wandering and elopement. 4. Review of Resident #58's 30 day MDS assessment dated 2/20/17 revealed it had been corrected to show wandering behaviors occurred daily. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction. Refer to F-323 "J"	F 278		
F 280 SS=J	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280	**F 280 Right to Participate Planning Care – Revise CP** 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 58 was transferred to the hospital post incident on January 17, 2017. Upon his/her return to the facility on January	

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	445190	A. BUILDING _____ B. WING _____	03/02/2017

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F 280	Continued From page 12 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 280	24, 2017, a new wandering and elopement assessment was completed and his/her care plan updated to identify the resident's wandering/elopement triggers and interventions to mitigate those triggers. The facility was in the process of installing a wanderguard system at the time of the incident and at this time all exit doors are alarmed as well as the courtyard door. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: The facility staff were in-serviced by the facility DON / Administrator on the following on 2/17/17 through 2/20/17 during face to face training/lecture sessions (and for those not	

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F 280	Continued From page 13 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, review of facility Incident/Accident reports and interviews, the facility failed to revise the care plan after each elopement attempt for 1 Resident (#58) of 3 residents reviewed for wandering and elopement, of 29 residents reviewed. The facility's failure resulted in Resident #58 eloping from the facility, sustaining an open ("if the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken	F 280	attending either of these sessions they were in serviced in the same manner before their next scheduled shift) i. Dementia: types of dementia, causes and behavioral symptoms ii. Wandering behaviors and identification of resident specific "triggers" for wandering and elopement behaviors iii. Elopement risk factors iv. Wandering risk assessment completed on admission, quarterly and with any significant change in condition. v. Monitoring functionality of the wanderguard system: vi. Each resident's wanderguard sensor is checked for functionality each shift and documented on the MAR. vii. Each alarmed exit door is tested for functionality daily by the Maintenance Director or his designee and on weekends by the day shift supervisor. viii. Developing and implementing an effective interdisciplinary plan of care for the resident at risk for wandering / elopement	

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F 280	Continued From page 14 bone, the fracture is called an "open" or compound fracture") fracture to her arm requiring surgical repair, placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office. The findings included: Review of the facility's policy "Wandering and Elopement" revised 8/4/03, revealed "...Purpose: To provide specific guidelines regarding assessment and care of the resident with the potential to wander and/or elope...The facility will provide preventative interventions as necessary for the safety of the resident...A care plan will be developed and implemented for each resident that is identified as at risk for wandering and/or elopement...Resident discovered missing from the facility...Upon return to the facility, the charge nurse should...Implement interventions to prevent further elopement...update the resident's care plan with elopement precautions..." Medical record review revealed Resident #58 was admitted on 6/13/13. Her diagnoses included Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, History of Breast Cancer, Osteoporosis and Depression. Review of a Brief Interview for Mental Status (BIMS) dated 2/8/16 revealed a score of 3,	F 280	ix. The Cambridge House's policy and procedure for Wandering and Elopement/ Managing Elopement including how to respond to a door alarm or missing resident: x. For the Resident observed attempting to leave the premises: 1. All personnel are to report any resident attempting to leave the premises to the charge nurse as soon as possible. 2. If an employee observes a resident leaving the premises, he/she should: a. Approach the resident calmly and walk with the resident. Have a side-by-side conversation and use verbal re-direction and distraction as you walk. b. Avoid confrontation and refrain from overpowering the resident. c. If the resident resists assistance to return and is in imminent danger, contact guidance may be utilized. d. Obtain assistance from other staff members in the immediate vicinity, if necessary. e. Instruct another staff member to inform the charge nurse that the resident has left the premises.	March 24, 2017

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F 280	Continued From page 15 indicating Resident #58 had a severe cognitive impairment. Medical record review of Review of Resident #58's care plan revealed an intervention for wandering and elopement " ...Problem/Need ...Problem Onset: 2/9/16 ...At risk for wandering and elopement r/t [related to] hx [history] of wanderin ...monitor q [every] 15 min's [minutes] and redirect as needed ...mental health eval [evaluation] + [and] review meds [medications] ..." Review of a facility Incident/Accident Report dated 2/23/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the 500 hallway door. Review of the accident report revealed " ...door alarm sounding, resident went out the 500 hall door to the outside of the building, brought back in by... [Certified Nursing Assistant[CNA] #2] ... and ... [CNA #3] ..." Resident was alert but confused and had no injuries. Review of the care plan problem onset date 2/9/16 "At risk for wandering and elopement" revealed the intervention added for 2/23/16 elopement was " ..above interventions in place,.." referring to the interventions that were already on the care plan dated 2/9/16. The care plan was not revised with any new interventions to prevent elopement. Review of the facility Incident/Accident Report dated 3/10/16 revealed Resident #58 had eloped from the facility at 8:45 PM. Resident #58 was found outside the front doors in the parking lot. Review of the accident report revealed " ...resident went out front door + [and] made her way to front parking lot. found by nursing staff +	F 280	3. Upon return to the facility, the charge nurse will: a. Examine the resident for injuries. b. Implement interventions to prevent further elopement. (Refer to the "Wandering and Elopement Development of the Care Plan) c. Notify the resident's attending physician of the incident. d. Notify the Director of Nursing. e. Notify the resident's responsible party/legal representative of the incident. f. Complete and file an incident report. g. Make appropriate notations in the resident's medical record and update the resident's plan of care to include elopement precautions. h. Document the incident on the 24-hour report. xi. For the Resident discovered missing from the facility. 1. All personnel are to report any resident suspected of being missing to the charge nurse as soon as possible. 2. If an employee discovers that a resident is missing from the facility, he/she should:	

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F 280	Continued From page 16 [and] brought back into building ..." Resident was alert but confused and had no injuries. ...". Review of the care plan problem dated 2/9/16 revealed the intervention added for 3/16/16 elopement was "...continue above interventions..." No new interventions to prevent the resident from exiting the building were implemented on the care plan. Review of a facility Incident/Accident Report dated 6/10/16 revealed Resident #58 had eloped from the facility at 4:10 PM. Resident #58 was found outside the 500 hallway. Review of the accident report revealed "...resident observed by CNA outside 500 hall rolling down the sidewalk..." The report indicated the resident was alert with intermittent confusion and had no injuries. Review of the care plan revealed the intervention added for 6/10/16 elopement was "...continue above interventions..." The care plan was not revised to reflect any new interventions implemented to prevent the resident from eloping. Review of the facility Incident/Accident Report dated 1/17/17 revealed Resident #58 had eloped from the facility at 9:00 PM. Resident #58 was found outside the 400 hallway exit. Review of the accident report revealed " ...called to eastwing by CNA's + [and] hospitality aide, found resident lying outside, at bottom of 400 exit hall ramp w/c [wheelchair] beside her on stomach ..." Continued review revealed injuries sustained were " ...abraision/ skin tear nose, wrist swollen ..." Cognitive status was marked as "alert" and "confused". Emergency Medical Services were called and transported Resident #58 to the hospital for admission and surgical repair of an	F 280	a. Determine if the resident is out on an authorized leave or pass. If not; b. Notify the charge nurse immediately. He/she will then direct a search of the building(s) and premises including all areas of the building. If not located; 3. The charge nurse will direct a search of the facility grounds using the "Search Grid for Elopement" – facility specific for indoors and outdoors of the facility. 4. The charge nurse will take a resident headcount. 5. Notify the administrator and director of nursing as soon as possible and within 30 minutes. 6. The Director of Nursing, or designee, will coordinate the following search procedure: a. Divide the local area around the facility and assign a staff person to search each area and report to the coordinator when the search is complete.	

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F 280	Continued From page 17 open fracture to the right arm. Review of the care plan dated 2/3/17 revealed "At risk for wandering and elopement" and revealed the intervention for the elopement was "...continue above interventions..." referring to the same interventions since 2/9/16. The care plan was not revised with new interventions to prevent the resident from exiting the facility after the elopement on 1/17/17 which resulted in injuries. Observation of Resident #58 on 2/16/17 at 10:00 AM, revealed the resident in her wheelchair, using her feet and left hand to move the wheelchair around the facility. Interview with Social Worker #1 on 2/16/17 at 10:30 AM in the conference room, revealed Resident #58 did exhibit exit seeking behaviors, and "...had eloped from the facility before..." Interview with Director of Nursing (DON) on 2/16/17 at 12:30 PM in the conference room, confirmed the facility failed to revise the care plan with new interventions to prevent further elopement after each elopement attempt. Observation of Resident #68 on 2/16/17 at 1:30 PM, revealed the resident in her wheelchair, using her feet and left hand to move the wheelchair around the facility. Interview with the Administrator on 2/16/17 at 9:45 PM in the conference room, confirmed the facility failed to revise the care plan with new interventions to prevent further elopement. The Immediate Jeopardy was effective from 1/17/17 to 3/1/17. The facility presented an	F 280	b. Determine the areas/sites in the community with which the resident may have familiarity, (stores, restaurants, or home). Assign necessary staff to search these areas. 7. If the resident is not located within one hour, notification should include, but is not limited to: a. Responsible Party b. Resident's physician c. Local police d. Hospitals, emergency rooms 8. Upon return to the facility, the charge nurse should: a. Examine the resident for injuries. b. Implement interventions to prevent further elopement. (Refer to the "Wandering and Elopement Development of the Care Plan") c. Notify the search team members, the administrator and the director of nursing that the resident has been returned to the facility. d. Notify the resident's attending physician of the incident. e. Notify the resident's responsible party/legal representative of the incident. f. Complete and file an incident report.	

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F 200	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 60 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...If ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking abated ...the Director of Nursing will be notified .." Continued review of care plan revealed " ..2/23/17 Wanderguard placed on Resident check Wanderguard q [every] shift by door accuracy . "	F 280	g. Make appropriate notations in the resident's medical record and update the resident's care plan with elopement precautions. h. Document the incident on the 24-hour report. i. The Administrator/designee will ensure a completed report is forwarded to Risk Management and all required state reporting agencies. All employees were tested on their retention of the information presented at these in-service sessions by March 2, 2017. If an employee did not score 80% or higher they were retrained on the above information. This in-service is also included in the new hire orientation process and reviewed annually with all employees. F280 continued (see attached pages)	March 24, 2017

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F 280	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...if ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking ...abated ...the Director of Nursing will be notified ..." Continued review of care plan revealed " ...2/23/17 Wanderguard placed on Resident ...check Wanderguard q [every] shift by door accuracy ..."	F 280	Elopement drills were held on February 17, 2017 for the 7am to 7pm shift and on February 18, 2017 for the 7pm to 7am shift. An elopement drill will be held by the Administrator or his designee on each shift twice a year with an assessment of the staff performance and adherence to facility policy during the drill presented to the QAPI committee for review and further recommendations The DON ascertained that 100% of current residents wandering assessments were completed by February 19, 2017. The DON will ascertain that the wandering assessment is completed on all residents upon admission, quarterly and with a significant change. The wandering and elopement risk assessments for all current residents were reviewed by the DON and/or designee and all residents identified as an elopement risk had their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers;	

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F 280	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...if ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking ...abated ...the Director of Nursing will be notified ..." Continued review of care plan revealed " ...2/23/17 Wanderguard placed on Resident ...check Wanderguard q [every] shift by door accuracy ..."	F 280	interventions to minimize the resident's wandering/elopement behavior and interventions to mitigate their individual elopement risk factors by March 1, 2017. The wandering and elopement risk assessments for all residents will continue to be reviewed by a licensed nurse and all residents identified as an elopement risk have their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers; interventions to minimize the resident's wandering/elopement behavior; and interventions to mitigate their individual elopement risk factors. For residents identified at risk for wandering/elopement the following protective measures are taken: • Photo identification will be placed in a private area of the nursing stations and at the front desk. This was completed on February 19, 2017. • The resident will wear a name band with the resident's name,	

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F 280	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...if ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking ...abated ...the Director of Nursing will be notified ..." Continued review of care plan revealed " ...2/23/17 Wanderguard placed on Resident ...check Wanderguard q [every] shift by door accuracy ..."	F 280	facility address and phone number clearly marked. This was completed on February 19, 2017. • The resident will be wear a wanderguard sensor. Completed on February 21, 2017. • The resident's care plan will be updated with interventions to minimize the resident's wandering/elopement behavior; identified wandering patterns or triggers. Completed on March 1, 2017. The Interdisciplinary team has instituted a detailed plan of care as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. The plan of care identifies triggers for wandering/elopement behaviors and interventions have been implemented to minimize those triggers as of March 1, 2017. If a resident is actively exit seeking or is displaying other high risk behavior and cannot be easily redirected s/he will be placed on 1:1 monitoring until the exit seeking or other high risk behavior has abated. The Director of Nursing will be	

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F 280	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...if ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking ...abated ...the Director of Nursing will be notified ..." Continued review of care plan revealed " ...2/23/17 Wanderguard placed on Resident ...check Wanderguard q [every] shift by door accuracy ..."	F 280	notified immediately and s/he will assess staffing needs of the facility, assigning staff to complete the 1:1 monitoring and calling in additional staff as indicated. This monitoring and the resident's response will be documented in the nurse's notes by the charge nurse for each shift the resident is placed on 1:1 monitoring. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: The Director of Nursing and/or her designee has completed a 100% audit of the resident population to ascertain their wandering & elopement risk assessment had been completed according to facility policy by February 19, 2017. The Director of Nursing and/or designee has ascertained that those residents identified as at risk for elopement are wearing a wanderguard sensor, that each resident's sensor is checked for functionality every shift and documented on the medication administration record	

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F 280	Continued From page 18 acceptable Allegation of Compliance and implementation of the AOC was validated by interviews conducted by the surveyors to validate the staff were in-serviced on the following policies: Wandering and Elopement Wandering, Unsafe Resident 1. Conducted interviews beginning on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy- Wandering, Unsafe Resident, and the effect these policies had on staffing levels. 2. Observation of Residents #58, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers. 3. Review of medical record and care plans for Residents #58, #10, and #68, on 3/2/17 at 2:30 PM revealed their care plans had been updated to reflect changes. Continued review revealed "...if ...exit seeking or is displaying other high risk behaviors ...s/he will be placed on 1:1 monitoring until exit seeking ...abated ...the Director of Nursing will be notified ..." Continued review of care plan revealed " ...2/23/17 Wanderguard placed on Resident ...check Wanderguard q [every] shift by door accuracy ..."	F 280	and that each alarmed exit door is checked for functionality daily by the Maintenance Director and/or designee, that the residents care plan has been updated to reflect their wandering triggers completed on March 1, 2017. The Director of Nursing or her designee will continue to complete an audit of 20% of the resident population to ascertain that their wandering & elopement risk assessment has been completed according to facility policy, that those residents identified as at risk for elopement are wearing a wanderguard sensor, that each residents sensor is checked for functionality every shift and documented on the medication administration record and that each alarmed exit door is checked for functionality daily by the Maintenance Director or his designee, that the residents care plan has been updated to reflect their wandering triggers and interventions implemented to mitigate those wandering triggers.	

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F 280	Continued From page 19 Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction. Refer to F-323 "J"	F 280		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323	**F 323 Free of Accident Hazards/Supervision/Devices** 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 58 was transferred to the hospital post incident on January 17, 2017. Upon his/her return to the facility on January 24, 2017, a new wandering and elopement assessment was completed and his/her care plan updated to identify the resident's wandering/elopement triggers and interventions to mitigate those triggers. The facility was in the process of installing a wanderguard system at the time of the incident and at this time all exit doors are alarmed as well as the courtyard door	

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F 323	Continued From page 20 Based on review of facility policy, medical record review, review of facility Incident/Accident Reports, observations and interview, the facility failed to provide adequate supervision to prevent unsafe wandering and elopement from the facility for 1 Resident (#58) of 3 residents reviewed for elopement risk, of 29 residents reviewed. The facility's failure resulted in Resident #58 eloping from the facility, sustaining an open fracture ("If the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") in her right arm requiring surgical repair, and abrasions and contusions to her face, placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office. F-323 resulted in Substandard Quality of Care. The findings included: Review of the facility's policy "Wandering and Elopement," revised 8/4/03, revealed "...Purpose: To provide specific guidelines regarding assessment and care of the resident with the potential to wander and/or elope...The facility will provide preventative interventions as necessary for the safety of the resident...If the resident is identified as being at risk for elopement, the resident will be placed on q 15 minute [every 15 minutes] visual monitoring...The q 15 minute	F 323	2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: The facility staff were in-serviced by the facility DON / Administrator on the following on 2/17/17 through 2/20/17 during face to face training/lecture sessions (and for those not attending either of these sessions they were in serviced in the same manner before their next scheduled shift) i. Dementia: types of dementia, causes and behavioral symptoms ii. Wandering behaviors and identification of resident specific "triggers" for wandering and elopement behaviors iii. Elopement risk factors	

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F 323	Continued From page 21 visual monitoring will be recorded on the 'Wandering Resident Monitor' tool...Re-evaluation of resident for continuing q-15 minute checks will be done after 72 hours. Decision of IDT [Interdisciplinary Team] and Physician will be made at that point as to continue or discontinue based on behaviors demonstrated and documented while on q-15 minute checks...The facility will ensure any monitoring devices such as door alarms or sensor bracelets are operational 24 hours a day...The nurse/designee will check each door alarm q shift and record on 'Door Alarm Maintenance Checklist'...If there is a problem noted with the door alarm, the facility will post a staff member at the exit door until door alarm is functional...All personnel are to report any resident attempting to leave the premises to the charge nurse as soon as possible...Resident discovered missing from the facility...Upon return to the facility, the charge nurse should...Implement interventions to prevent further elopement..." Medical record review revealed Resident #58 was admitted to the facility on 6/13/13 with diagnoses including Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, Osteoporosis and Depression. Review of the annual Minimum Data Set (MDS) assessment dated 2/8/16 revealed a Brief Interview for Mental Status score of 3, indicating the resident had a severe cognitive impairment. Review of the care plan dated 2/9/16 revealed a problem area of wandering and elopement for Resident #50.	F 323	iv. Wandering risk assessment completed on admission, quarterly and with any significant change in condition. March 24, 2017 v. Monitoring functionality of the wanderguard system: vi. Each resident's wanderguard sensor is checked for functionality each shift and documented on the MAR. vii. Each alarmed exit door is tested for functionality daily by the Maintenance Director or his designee and on weekends by the day shift supervisor. viii. Developing and implementing an effective interdisciplinary plan of care for the resident at risk for wandering / elopement ix. The Cambridge House's policy and procedure for Wandering and Elopement/ Managing Elopement including how to respond to a door alarm or missing resident: x. For the Resident observed attempting to leave the premises: 1. All personnel are to report any resident attempting to leave the premises to the charge nurse as soon as possible.	

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F 323	Continued From page 22 Review of a facility Incident/Accident Report dated 2/23/16 revealed Resident #58 had eloped from the facility at 2:15 PM. Resident #58 was found outside the facility by the 500 hallway exit door. Continued review of the accident report revealed " ...door alarm sounding, resident went out the 500 hall door to the outside of the building, brought back in by...[Certified Nursing Assistant [CNA] #2] ... and ...[CNA #3] ..." Resident with "...no apparent ..." injuries noted. Level of consciousness was marked as "...alert with confusion..." Review of the care plan problem area wandering and elopement, revised 2/23/16 revealed "above interventions in place", and no new interventions were implemented. Review of a visual observation form revealed the staff charted every 15 minute visual observation of Resident #58 for 72 hours after her elopement on 2/23/16. Review of the Wandering and Elopement Assessment dated 2/23/16 revealed Resident #58 was assessed as a wandering and elopement risk. Review of a facility Incident/Accident Report dated 3/16/16 revealed Resident #58 had eloped from the facility at 8:45 PM. Resident #58 was found outside the front doors in the parking lot. Continued review of the accident report revealed "...resident went out front door + [and] made her way to front parking lot. found by nursing staff + [and] brought back into building..." Resident with ". no apparent...injuries noted. Level of consciousness was marked as " ..alert/confused..."	F 323	2. If an employee observes a resident leaving the premises, he/she should: a. Approach the resident calmly and walk with the resident. Have a side-by-side conversation and use verbal re-direction and distraction as you walk. b. Avoid confrontation and refrain from overpowering the resident. c. If the resident resists assistance to return and is in imminent danger, contact guidance may be utilized. d. Obtain assistance from other staff members in the immediate vicinity, if necessary. e. Instruct another staff member to inform the charge nurse that the resident has left the premises. 3. Upon return to the facility, the charge nurse will: a. Examine the resident for injuries. b. Implement interventions to prevent further elopement. (Refer to the "Wandering and Elopement Development of the Care Plan) c. Notify the resident's attending physician of the incident. d. Notify the Director of Nursing. e. Notify the resident's responsible party/legal representative of the incident.	

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F 323	Continued From page 23 Review of the care plan dated 3/16/16 revealed "cont [continue] above interventions" and no new interventions were implemented. Review of a visual observation form revealed the staff charted every 15 minute visual observations of Resident #58 for 72 hours after her elopement on 3/16/16. Review of the quarterly MDS assessment dated 4/29/16 revealed a Brief Interview for Mental Status score of 3, indicating the resident had a severe cognitive impairment. Review of Wandering and Elopement Assessment review dated 4/26/16 revealed Resident #58 with "...no further episodes of wandering noted..." Review of a facility Incident/Accident Report dated 5/10/16 revealed Resident #58 had eloped from the facility at 4:10 PM. Resident #58 was found outside the facility by the 500 hallway exit door. Continued review of the accident report revealed " ...resident observed by CNA outside 500 hall rolling down the sidewalk ..." Resident with "...no apparent ..." injuries noted. Level of consciousness was marked as " ...alert with intermit [intermittent] confusion ..." Review of the care plan problem area wandering and elopement, dated 5/10/16 revealed "cont [continue] above interventions" and no new interventions were implemented. Review of a visual observation form revealed the staff charted every 15 minute visual observations of Resident #58 for 72 hours after her elopement	F 323	f. Complete and file an incident report. g. Make appropriate notations in the resident's medical record and update the resident's plan of care to include elopement precautions. h. Document the incident on the 24-hour report. xi. For the Resident discovered missing from the facility. 1. All personnel are to report any resident suspected of being missing to the charge nurse as soon as possible. 2. If an employee discovers that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. If not; b. Notify the charge nurse immediately. He/she will then direct a search of the building(s) and premises including all areas of the building. If not located; 3. The charge nurse will direct a search of the facility grounds using the "Search Grid for Elopement" – facility specific for indoors and outdoors of the facility.	

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F 323	Continued From page 24 on 5/10/16. Review of the annual MDS assessment dated 12/14/16 revealed a Brief Interview for Mental Status score of 3, indicating the resident had a severe cognitive impairment. Review of a nurse's note dated 1/17/17 revealed: at 8:00 PM " ...caught resident trying to open outside door next to her room ...at 8:30 PM CNA brought resident back ...from around door at room 509 ..." Review of a nurse's note dated 1/17/17 revealed at 8:15 PM, "...I saw [Resident #58]... about 8:15 on T hall trying to go out that door...followed me down the 500 hall wanting to go out that door..." Review of a facility Incident/Accident Report dated 1/17/17 revealed Resident #58 had eloped from the facility at 9:00 PM. Resident #58 was found outside the 400 hallway exit. Review of the accident report revealed "...called to eastwing by CNA's + (and) hospitality aide, found resident lying outside, at bottom of 400 exit hall ramp w/c (wheelchair) beside her) on stomach..." Continued review revealed injuries sustained were "...abraision/ skin tear nose, wrist swollen..." Cognitive status was masked as "alert" and "confused". Emergency Medical Services were called and transported Resident #58 to the hospital for admission. Review of the hospital Emergency Department history & (and) physical, dated 1/17/17, revealed "...the patient is confused and history is provided by her daughter...tonight the patient went out the door in her wheelchair, slid down a sidewalk where she turned over and tried to catch herself	F 323	4. The charge nurse will take a resident headcount. 5. Notify the administrator and director of nursing as soon as possible and within 30 minutes. 6. The Director of Nursing, or designee, will coordinate the following search procedure: a. Divide the local area around the facility and assign a staff person to search each area and report to the coordinator when the search is complete. b. Determine the areas/sites in the community with which the resident may have familiarity, (stores, restaurants, or home). Assign necessary staff to search these areas. 7. If the resident is not located within one hour, notification should include, but is not limited to: a. Responsible Party b. Resident's physician c. Local police d. Hospitals, emergency rooms 8. Upon return to the facility, the charge nurse should: a. Examine the resident for injuries.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HOUSE, THE	250 BELLEBROOK RD BRISTOL, TN 37620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 with her right arm ...states...has not been ambulatory in 3 years and is wheelchair bound ...the patient has significant bruising to her face and open right wrist fracture..." Review of the hospital discharge Summaries, dated 1/24/17, revealed " ...open right distal radius and ulnar fracture, S/P (status post) open reduction/ external fixator application of right distal radius fracture on 1/18/17 ...Acute blood-loss anemia ..." Medical record review revealed Resident #58 returned to the facility on 1/24/17. Review of a Wandering and Elopement Risk Assessment dated 1/24/17 revealed Resident #58 to be assessed as a wandering and elopement risk. Review of a visual observation form revealed the staff charted every 15 minute visual observation of Resident #58 for 72 hours after her return from the hospital on 1/24/17. Review of the care plan revealed "1/17/17 episodes of wandering" and "cont [continue] above interventions" and no new interventions were implemented. Observation of Resident #58 on 2/16/17 at 10:00 AM, revealed the resident in her wheelchair, using her feet and left hand to move the wheelchair around the facility. Interview with the Hospitality Aid on 2/16/17 at 12:00 PM per telephone, confirmed she found Resident #58 outside, on the ground at the 400	F 323	b. Implement interventions to prevent further elopement. (Refer to the "Wandering and Elopement Development of the Care Plan") c. Notify the search team members, the administrator and the director of nursing that the resident has been returned to the facility. d. Notify the resident's attending physician of the incident. e. Notify the resident's responsible party/legal representative of the incident. f. Complete and file an incident report. g. Make appropriate notations in the resident's medical record and update the resident's care plan with elopement precautions. h. Document the incident on the 24-hour report. i. The Administrator/designee will ensure a completed report is forwarded to Risk Management and all required state reporting agencies. All employees were tested on their retention of the information presented at these in-service sessions by March 2, 2017. If an	

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F 323	Continued From page 26 Exit Hall door, at the bottom of a concrete ramp on 1/17/17 at 9:00 PM after seeing her on the ground from another resident's room window. Observation of Resident #58 on 2/16/17 at 1:30 PM, revealed the resident was in her wheelchair, using her feet and left hand to move the wheelchair around the facility. Interview with Licensed Practical Nurse (LPN) #1 on 2/16/17 at 8:50 PM in the conference room, revealed she was aware Resident #58 was an elopement risk and had attempted three times to elope on 1/17/17 after 8:00 PM, prior to her getting out of the building on 1/17/17 at 9:00 PM. Continued interview revealed there was not enough staff on the evening of 1/17/17 to provide supervision to ensure Resident #58 did not leave the building. She also confirmed the resident had a "noticeable change in her behavior and demeanor when she was going to try and elope". The noticeable behaviors exhibited by Resident #58 to indicate she might elope were increased wandering in her wheelchair and going to the exit doors and looking outside. Resident #58 would not try to exit seek every time but would look outside. The LPN confirmed staff did not provide supervision to prevent Resident#58 from eloping. Interview with CNA#1 on 2/16/17 at 9:00 PM in the conference room, confirmed Resident #58 was a known elopement risk and had attempted three times to elope at 8:00 PM, 8:15 PM, and 8:30 PM on 1/17/17 prior to her elopement at 9:00 PM. Continued interview revealed there was not enough staff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed the resident had a "noticeable change in	F 323	employee did not score 80% or higher they were retrained on the above information. This in-service is also included in the new hire orientation process and reviewed annually with all employees. Elopement drills were held on February 17, 2017 for the 7am to 7pm shift and on February 18, 2017 for the 7pm to 7am shift. An elopement drill will be held by the Administrator or his designee on each shift twice a year with an assessment of the staff performance and adherence to facility policy during the drill presented to the QAPI committee for review and further recommendations The DON ascertained that 100% of current residents wandering assessments were completed by February 19, 2017. The DON will ascertain that the wandering assessment is completed on all residents upon admission, quarterly and with a significant change.	

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F 323	Continued From page 27 her behavior and demeanor when she was going to try and elope". The behaviors exhibited by Resident #58 were increased wandering in her wheelchair and going to the exit doors and looking outside. Resident #58 would not try to exit seek every time but would look outside. Interview with the Administrator on 2/16/17 at 9:30 PM, at the 400 Hall Exit door, confirmed the door alarm did not sound on 1/17/17, when Resident #58 exited the building, because it had a dead battery. Observation of the 400 Exit Hall door on 2/16/17 at 9:30 PM, revealed a concrete ramp approximately12 feet long, leading from the door to a sidewalk, edged with a metal railing at the bottom of the ramp and on one side. Interview with the Family Nurse Practitioner, (FNP), on 2/17/17 at 7:30 AM in the conference room, revealed he did not remember their practice being notified about Resident #58's elopements on 2/23/16, 3/16/16 and 5/10/16. Continued interview revealed that when someone has as many elopements as Resident #58, they start looking for a secure unit for the resident to ensure their safety. Interview with the Medical Director on 2/17/17 at 10:40 AM per telephone, revealed he did not remember being told about Resident #58's elopements that occurred on 2/23/16, 3/16/16, and 5/10/16. The Medical Director stated he "signed the incident reports regarding these days but did not read them". Continued interview revealed the Medical Director would have looked at transferring Resident #58 to another facility that had a secure unit for her safety, had he	F 323	The wandering and elopement risk assessments for all current residents were reviewed by the DON and/or designee and all residents identified as an elopement risk had their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers; interventions to minimize the resident's wandering/elopement behavior and interventions to mitigate their individual elopement risk factors by March 1, 2017. The wandering and elopement risk assessments for all residents will continue to be reviewed by a licensed nurse and all residents identified as an elopement risk have their care plans revised by the interdisciplinary team to include identification of the resident's wandering patterns or triggers; interventions to minimize the resident's wandering/elopement behavior; and interventions to mitigate their individual elopement risk factors.	

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F 323	Continued From page 28 known about the number of elopements. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by: 1. Observing the main entrance egress doors for signage of "Notice to Visitors" (not to let residents out of the facility without staff notification), and proper functioning of anti-elopement system on the following doors: A. Main entrance egress doors B. Sun room egress doors C. 400 Hall/Conference room fire exit door D. 500 Hall fire exit door E. 300 Hall fire exit door F. Dining room egress door G. 100/200 Hall ambulance entrance door All egress doors had (1) a 15 seconds delayed mag lock with key pad implemented after the elopements on 2/9/17; (2) a wanderguard alarm system (if a resident with a wanderguard bracelet attempts to exit the doors lock, alarms sound, and the door will not open until the resident with the wanderguard is removed from the door area. The wanderguard bracelet system was installed and working on 2/21/17. Observation of Residents #56, #10, and #68 on 3/2/17 at 2:00 PM revealed them all to have their wander guard bracelets in place. These three residents were assessed as wanderers.	F 323	For residents identified at risk for wandering/elopement the following protective measures are taken: • Photo identification will be placed in a private area of the nursing stations and at the front desk. This was completed on February 19, 2017. • The resident will wear a name band with the resident's name, facility address and phone number clearly marked. This was completed on February 19, 2017. • The resident will be wear a wanderguard sensor. Completed on February 21, 2017. • The resident's care plan will be updated with interventions to minimize the resident's wandering/elopement behavior; identified wandering patterns or triggers. Completed on March 1, 2017. The Interdisciplinary team has instituted a detailed plan of care as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. The plan of care identifies triggers for	

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F 323	Continued From page 29 2. All audible door alarms placed on the Fire and Egress doors will continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 3. Observed the staff response to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM 4. Interviewed 6 visitors on 3/2/16 between 8:00 AM and 12:00 PM regarding their knowledge about not letting residents out of the building without notifying the nursing staff first, and how to properly sign out a resident from the facility. 5. Reviewed the facility's in-service records to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 6. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, and implementation of the policy Wandering, Unsafe Resident. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by	F 323	wandering/elopement behaviors F323 continued (see attached pages)	March 24, 2017

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F 323	Continued From page 29 2. All audible door alarms placed on the Fire and Egress doors will continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 3. Observed the staff response to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM. 4. Interviewed 6 visitors on 3/2/16 between 8:00 AM and 12:00 PM regarding their knowledge about not letting residents out of the building without notifying the nursing staff first, and how to properly sign out a resident from the facility. 5. Reviewed the facility's in-service records to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 6. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, and implementation of the policy Wandering, Unsafe Resident. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by	F 323	and interventions have been implemented to minimize those triggers as of March 1, 2017. If a resident is actively exit seeking or is displaying other high risk behavior and cannot be easily redirected s/he will be placed on 1:1 monitoring until the exit seeking or other high risk behavior has abated. The Director of Nursing will be notified immediately and s/he will assess staffing needs of the facility, assigning staff to complete the 1:1 monitoring and calling in additional staff as indicated. ~~This~~ monitoring and the resident's response will be documented in the nurse's notes by the charge nurse for each shift the resident is placed on 1:1 monitoring. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: The Director of Nursing and/or her designee has completed a 100% audit of the resident population to ascertain their wandering & elopement risk	

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F 323	Continued From page 30 the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction.	F 323		
F 353 SS=J	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (b) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353	**F 353 Sufficient Staffing 24-hour Nursing Staff per Care Plans** 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 58 was transferred to the hospital post incident on January 17, 2017. Upon his/her return to the facility on January 24, 2017, a new wandering and elopement assessment was completed and his/her care plan updated to identify the resident's wandering/elopement triggers and interventions to mitigate those triggers. The facility was in the process of installing a wanderguard system at the time of the incident and at this time all exit doors are alarmed as well as the courtyard door. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:	

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F 353	Continued From page 31 duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on review of the monthly staffing schedule, medical record review, observation, review of facility Incident/Accident Reports and interview the facility failed to be adequately staffed to provide supervision to prevent an elopement from the facility for 1 resident (#58) of 3 residents reviewed for wandering and elopement risk, of 29 residents reviewed. The facility's failure resulted in Resident #58 eloping from the facility sustaining an open fracture ("if the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") in her right arm requiring surgical repair, placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office.	F 353	All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: The facility staff were in-serviced by the facility DON / Administrator on the following on 2/17/17 through 2/20/17 during face to face training/lecture sessions (and for those not attending either of these sessions they were in serviced in the same manner before their next scheduled shift) i. Dementia: types of dementia, causes and behavioral symptoms ii. Wandering behaviors and identification of resident specific "triggers" for wandering and elopement behaviors iii. Elopement risk factors iv. Wandering risk assessment completed on admission, quarterly and with any significant change in condition.	March 24, 2017

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F 353	Continued From page 32 The findings included: Review of the January 2017 Staffing Schedule for the evening/night shift (7 PM to 7AM) revealed staffing of 1 Registered Nurse (RN) supervisor, 2 Licensed Practical Nurses (LPN), 5 Certified Nursing Assistants (CNA), and 1 Hospitality Aide on the evening shift only. Medical Record review revealed Resident #58 was admitted to the facility on 6/13/13 with diagnoses including Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, Osteoporosis and Depression. Review of care plan dated 2/9/16 revealed a problem area of wandering and elopement for Resident #58. Review of the annual Minimum Data Set (MDS) assessment dated 12/14/16 revealed a Brief Interview for Mental Status score of 9, indicating the resident had a severe cognitive impairment. Review of a Wandering and Elopement Assessment dated 12/14/16 revealed Resident #58 was a wandering and elopement risk. Review of the facility Incident/Accident Report dated 1/17/17 revealed Resident #58 had eloped from the facility at 9:00 PM. Resident #58 was found outside the 400 hallway exit. Review of the accident report revealed ".. called to eastwing by CNA's 1 [and] hospitality aide, found resident lying outside, at bottom of 400 exit hall ramp w/c [wheelchair] beside her on stomach..." Continued review revealed injuries sustained were "...abraision/ skin tear nose, wrist swollen..."	F 353	v. Monitoring functionality of the wanderguard system: vi. Each resident's wanderguard sensor is checked for functionality each shift and documented on the MAR. vii. Each alarmed exit door is tested for functionality daily by the Maintenance Director or his designee and on weekends by the day shift supervisor. viii. Developing and implementing an effective interdisciplinary plan of care for the resident at risk for wandering / elopement ix. The Cambridge House's policy and procedure for Wandering and Elopement/ Managing Elopement including how to respond to a door alarm or missing resident: x. For the Resident observed attempting to leave the premises: 1. All personnel are to report any resident attempting to leave the premises to the charge nurse as soon as possible. 2. If an employee observes a resident leaving the premises, he/she should: a. Approach the resident calmly and walk with the resident. Have a	

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F 353	Continued From page 33 Cognitive status was marked as "alert" and "confused". Emergency Medical Services were called and transported Resident #58 to the hospital for admission. Review of the hospital Emergency Department history & (and) physical, dated 1/17/17, revealed "...tonight the patient went out the door in her wheelchair, slid down a sidewalk where she turned over and tried to catch herself with her right arm ...the patient has significant bruising to her face and open right wrist fracture..." Review of a nurse's note dated 1/17/17 revealed: at 8:00 PM, " ...caught resident trying to open outside door next to her room ...at 8:30 PM CNA brought resident back ...from around door at room 509 ..." Review of a nurse's note dated 1/17/17 revealed: at 8:15 PM, revealed "...I saw... about 8:15 on T hall trying to go out that door ...followed me down the 500 hall wanting to go out that door..." Interview with RN #1 on 2/16/17 at 11:45 AM, in the conference room revealed there was no staff member assigned to Resident #58 to provide increased supervision after the elopement attempts. Continued interview revealed "I was too busy admitting residents", when asked if one on one supervision had been implemented for Resident #58". Interview with the Hospitality Aid on 2/16/17 at 12:00 PM per telephone, confirmed she found Resident #58 outside on the ground on 1/17/17 at 9:00 PM after seeing her on the ground from another resident's room window.	F 353	side-by-side conversation and use verbal re-direction and distraction as you walk. b. Avoid confrontation and refrain from overpowering the resident. c. If the resident resists assistance to return and is in imminent danger, contact guidance may be utilized. d. Obtain assistance from other staff members in the immediate vicinity, if necessary. e. Instruct another staff member to inform the charge nurse that the resident has left the premises. 3. Upon return to the facility, the charge nurse will: a. Examine the resident for injuries. b. Implement interventions to prevent further elopement. (Refer to the "Wandering and Elopement Development of the Care Plan) c. Notify the resident's attending physician of the incident. d. Notify the Director of Nursing. e. Notify the resident's responsible party/legal representative of the incident. f. Complete and file an incident report. g. Make appropriate notations in the resident's medical record and update the resident's plan of care	

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F 353	Continued From page 34 Interview with Licensed Practical Nurse (LPN) #1 on 2/16/17 at 8:50 PM in the conference room, revealed she was aware Resident #58 was an elopement risk and had attempted three times to elope on 1/17/17 after 8:00 PM, prior to her getting out of the building on 1/17/17 at 9:00 PM. Continued interview revealed there was not enough staff on the evening of 1/17/17 to provide supervision to ensure Resident #58 did not leave the building. She also confirmed the resident had a "noticeable change in her behavior and demeanor when she was going to try and elope". The noticeable behaviors exhibited by Resident #58 to indicate she might elope were increased wandering in her wheelchair and going to the exit doors and looking outside. Resident #58 would not try to exit seek every time but would look outside. Continued interview revealed staff did not provide supervision to prevent Resident #58 from eloping, they would redirect her but did not provide increased supervision. Interview with CNA #1 on 2/16/17 at 9:00 PM in the conference room, confirmed Resident #58 was a known elopement risk and had attempted three times to elope at 8:00 PM, 8:15 PM, and 8:30 PM on 1/17/17 prior to her elopement at 9:00 PM. Continued interview revealed there was not enough staff on the evening 1/17/17 to provide supervision to prevent Resident #58 from leaving the building. Continued interview revealed the resident had a "noticeable change in her behavior and demeanor when she was going to try and elope". The behaviors exhibited by Resident #58 were increased wandering in her wheelchair and going to the exit doors and looking outside. Resident #58 would not try to exit seek every time but would look outside. Continued interview revealed staff would redirect	F 353	to include elopement precautions. h. Document the incident on the 24-hour report. xi. For the Resident discovered missing from the facility. 1. All personnel are to report any resident suspected of being missing to the charge nurse as soon as possible. 2. If an employee discovers that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. If not; b. Notify the charge nurse immediately. He/she will then direct a search of the building(s) and premises including all areas of the building. If not located; 3. The charge nurse will direct a search of the facility grounds using the "Search Grid for Elopement" – facility specific for indoors and outdoors of the facility. 4. The charge nurse will take a resident headcount. 5. Notify the administrator and director of nursing as soon as possible and within 30 minutes.	

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F 353	Continued From page 35 Resident #58, but did not have staff to provide increased supervision as they were "busy putting people to bed". The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, was received on 3/2/17 which removed the immediacy of the jeopardy, was received and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by: 1. All audible door alarms placed on the Fire and Egress doors will continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 2. Observed the staff response to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM. 3. Reviewed the facilities in-service records from 2/17/17 to 2/22/17 to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 4. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1	F 353	6. The Director of Nursing, or designee, will coordinate the following search procedure: a. Divide the local area around the facility and assign a staff person to search each area and report to the coordinator when the search is complete. b. Determine the areas/sites in the community with which the resident may have familiarity, (stores, restaurants, or home). Assign necessary staff to search these areas. F353 continued (see attached pages)	March 24, 2017

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F 353	Continued From page 35 Resident #58, but did not have staff to provide increased supervision as they were "busy putting people to bed". The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, was received on 3/2/17 which removed the immediacy of the jeopardy, was received and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by: 1. All audible door alarms placed on the Fire and Egress doors will continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 2. Observed the staff response to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM. 3. Reviewed the facilities in-service records from 2/17/17 to 2/22/17 to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 4. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1	F 353	ascertained that those residents identified as at risk for elopement are wearing a wanderguard sensor, that each resident's sensor is checked for functionality every shift and documented on the medication administration record and that each alarmed exit door is checked for functionality daily by the Maintenance Director and/or designee by February 21, 2017, that the residents care plan has been updated to reflect their wandering triggers completed on March 1, 2017. The Director of Nursing or her designee will continue to complete an audit of 20% of the resident population to ascertain that their wandering & elopement risk assessment has been completed according to facility policy, that those residents identified as at risk for elopement are wearing a wanderguard sensor, that each residents sensor is checked for functionality every shift and documented on the medication administration record and that each alarmed exit door is checked for functionality daily by the Maintenance Director or his	

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	445190	A. BUILDING _____ B. WING _____	03/02/2017

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F 353	Continued From page 35 Resident #58, but did not have staff to provide increased supervision as they were "busy putting people to bed". The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, was received on 3/2/17 which removed the immediacy of the jeopardy, was received and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by: 1. All audible door alarms placed on the Fire and Egress doors will continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 2. Observed the staff response to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:25 PM. 3. Reviewed the facilities in-service records from 2/17/17 to 2/22/17 to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 4. Conducted interviews beginning on 3/2/17 at 12:44 PM with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff 2 Rehab staff, 1	F 353	designee, that the residents care plan has been updated to reflect their wandering triggers and interventions implemented to mitigate those wandering triggers. This audit will be completed weekly for four weeks and then monthly for two months. The results of the audit will be presented to the QAPI committee for their review and further recommendations. 5. Date of Correction: March 24, 2017	

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F 353	Continued From page 36 Receptionist for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, implementation of the policy Wandering: Unsafe Resident, and making sure unsafe wandering residents are made 1:1 observation with notification of the Director of Nursing for staff replacement and supervision. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction. Refer to F-323 "J"	F 353		
F 501 SS=J	483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR (h) Medical director. (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the Medical Director Agreement, review of medical records, review of facility Incident/Accident Reports, and interview, the medical director failed to coordinate medical care after signing 4 of 4 elopement reports for 1 Resident (#58) of 3 residents reviewed for	F 501	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 58 was transferred to the hospital post incident on January 17, 2017. Upon his/her return to the facility on January 24, 2017, a new wandering and elopement assessment was completed and his/her care plan updated to identify the resident's wandering/elopement triggers and interventions to mitigate those triggers.. The facility was in the process of installing a wanderguard system at the time of the incident and at this time all exit	

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F 501	Continued From page 37 wandering and elopement of 29 residents reviewed. The facility's failure resulted in Resident #58 sustaining an open fracture ("if the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") requiring surgical repair and placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office. The findings included: Medical record review revealed Resident #58 was admitted on 8/13/13. Her diagnoses included Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, History of Breast Cancer, Osteoporosis and Depression. Review of the Medical Director Agreement effective date 1/1/2002, revealed under the Medical Director Duties "...Medical Director shall evaluate resident care provided in the Facility, and shall advise the Administrator in writing of any discrepancies or inadequacies in connection therewith..." Review of Resident #58's care plan dated 2/9/16, revealed "...Problem/Need ...Problem Onset: 2/9/16 ...At risk for wandering and elopement r/t [related to] hx [history] of wandering..."	F 501	doors are alarmed including the courtyard door. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: The Medical Director was in-serviced by the facility Administrator 3/1/17 on his responsibility for oversight of Incidents/Accidents and unusual events in the facility to include: 1) a thorough review of each Incident & Accident report before signing, 2) need to look for trends in resident behavior and or staff practices and 3) communicating concerns with resident behaviors and/or staff practices to administration and assist in	

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F 501	Continued From page 38 Review of a facility Incident/Accident Report dated 2/23/16 revealed Resident #58 had eloped from the facility at 2:16 PM. Resident #58 was found outside the 500 hallway door. Review of the accident report revealed " ...door alarm sounding, resident went out the 500 hall door to the outside of the building, brought back in by ... [Certified Nurse Assistant [CNA] #2]... and...[CNA #3]..." -Continued review confirmed the Medical Director signed the form 2/26/16. Review of a facility Incident/Accident Report dated 3/18/16 revealed Resident #58 had eloped from the facility at 8:45 PM. Resident #58 was found outside the front doors in the parking lot. Review of the accident report revealed "...resident went out front door + [and] made her way to front parking lot. found by nursing staff + [and] brought back into building..." Continued review revealed the Medical Director signed the form on 4/1/16 Review of a facility Incident/Accident Report dated 5/10/16 revealed Resident #58 had eloped from the facility at 4:10 PM. Resident #58 was found outside the 500 hallway. Review of the accident report revealed "...resident observed by CNA outside 500 hall rolling down the sidewalk..." Continued review revealed the Medical Director signed the form on 8/6/16, 3 months after the elopement. Continued review of a facility Incident/Accident Report dated 1/17/17 revealed Resident #58 had eloped from the facility at 9:00 PM. Resident #58 was found outside the 400 hallway exit. Review of the accident report revealed "...called to eastwing by CNA's + [and] hospitality aide, found resident lying outside, at bottom of 400 exit hall ramp w/c	F 501	developing and implementing an appropriate plan of correction. 4. The facility Administrator, DON and Medical Director will coordinate a trend analysis of all Incidents/Accidents at the monthly QAPI committee meeting to ascertain that individual resident trends and facility wide trends have been identified, root cause of the trend(s) identified and corrective measures implemented to address the root cause of the negative trend. The effectiveness of the corrective actions taken will be analyzed and further recommendations made by the committee as indicated. 5. Date of Correction: March 24, 2017	3/24/17

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F 501	Continued From page 39 [Wheelchair] beside her on stomach..." Continued review revealed injuries sustained were " ...abraision/ skin tear nose, wrist swollen..." Continued review revealed the Medical Director signed the form on 1/23/17. Interview with the Medical Director on 2/17/17 at 10:40 AM per telephone, revealed he did not remember being told about Resident #58's elopements that occurred on 2/23/16, 3/16/16, and 5/10/16. The Medical Director confirmed he "signed the incident reports regarding these days but did not read them". The Medical Director stated that if he would have known about the number of elopements that Resident #58 had he would have looked at transferring her to another facility that had a secure unit for her safety. Interview with the Administrator on 2/28/17 at 4:00 PM in her office, revealed the Administrator expected the Medical Director to read the incident reports, and not just sign them. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy was received on 3/2/17, and corrective actions were validated through review of documents, observation, and staff interviews conducted onsite on 3/2/17. The surveyor verified the allegation of compliance by: 1. Interview with the Administrator on 3/2/17 at 10:30 AM in her office, confirmed she and the Quality Assurance (QA) Coordinator were monitoring the Medical Director for compliance in reading the incident reports prior to signing them. 2. Interview with the QA Coordinator on 3/2/17	F 501		

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F 501	Continued From page 40 at 11:00 AM in her office, confirmed she was to monitor the Medical Director reading and signing the facility's Incident/Accident Reports on an ongoing basis. The QA Coordinator will maintain all Incident/Accident Reports reviewed and signed by the Medical Director. 3. Interview with the Medical Director on 3/2/17 at 2:16 PM, in the conference room, confirmed he was informed to fulfill his contractual agreement with the facility he was to read all Incident/Accident Reports prior to signing them. This will allow him to better coordinate medical care for residents in the facility. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction. Refer to F-323 "J"	F 501		
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 520	**F 520 QAA Committee – Members/Meet Quarterly/ Plans** All residents have the potential to be affected The QAPI committee was re-educated by the Administrator on March 1, 2017 on Root Cause Analysis and that when deficient practices are observed to immediately correct the actions and report to QA. Each deficient practice identified will be followed through the QAPI cycle of Plan-Do-Study Act. (PDSA Cycle) The QAPI committee, led by the facility Administrator and comprised of the Medical Director, Director of	

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F 520	Continued From page 41 administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (II) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility Incident/Accident Reports and interview, the facility's Quality Assurance (QA) Committee failed to ensure development of a plan to provide adequate supervision to prevent unsafe wandering and elopement from the facility; to ensure Minimum Data Set Assessments and care plans were completed accurately, to ensure sufficient nurse staffing for 1 resident (#58) with known for wandering and elopement, of 29 residents reviewed. The facility's failure resulted	F 520	Nursing, Administrator, Social Services Director, Activity Director, Dietary Manager, Therapy Manager and 2 direct care staff members at a minimum, will discuss any potential deficient practices observed and follow the PDSA Cycle. The Facility Quality Measures, internal Quality indicators, infection control reports, RD reports, pharmacy reports, and consultant reports, Medical Director Reports to QAPI Committee, monthly QAPI audits and survey reports will all be analyzed monthly by the QAPI committee to identify potential deficient practices and opportunities for improvement. Plans of correction will be developed and implemented for each opportunity identified followed by a reassessment to determine if the corrective action was implemented. Additional corrective action will be taken as indicated. Date of Correction: March 24, 2017	3/24/17

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F 520	Continued From page 42 in Resident #58 sustaining an open fracture ("If the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" or compound fracture") requiring surgical repair, and abrasions and contusions to her face, placing Resident #58 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 3/1/17 at 1:25 PM in her office. The findings included: Medical record review revealed Resident #58 was admitted on 6/13/13. Her diagnoses included Dysphagia, Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), Hypertension, Osteoporosis and Depression. Review of Resident #58's care plan dated 2/9/16, revealed "...Problem/Need...Problem Onset: 2/9/16...At risk for wandering and elopement r/t [related to] hx [history] of wandering.. " Medical record review and review of facility Incident/Accident reports revealed Resident #58 had been found outside the facility, after exiting the building (eloping) on three occasions, 2/23/16, 3/16/16, and 5/10/16. After each elopement, the facility monitored the resident with every 15 minute observations for 72 hours. The facility did not implement any new interventions or	F 520		

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F 620	Continued From page 43 revise the resident's care plan to prevent the resident from eloping again. Medical record review of the resident's MDS assessments revealed the resident was not identified as having wandering behaviors. Medical record review and review of facility Incident/Accident reports revealed the resident attempted to exit the building on 1/17/17 at 8:00 PM, 8:15 PM, and 8:30 PM, and was found outside of the building, lying on the ground with her wheelchair overturned, at 9:00 PM. The resident sustained abrasions and contusions to her face and suffered an open fracture of her wrist requiring surgical intervention. Interview with the Medical Director on 2/17/17 at 10:40 AM, revealed the Medical Director was a member of the QA Committee and attended the QA meetings. Continued interview revealed he did not remember being informed about Resident #58's elopements that occurred on 2/23/16, 3/16/16, and 5/10/16. The Medical Director stated that he was unaware of the resident's constant wandering and multiple attempts at elopement from the facility. Further interview revealed the Medical Director was unaware of any issues with residents wandering or elopements prior to the 1/31/17 QA meeting. Interview with Registered Nurse (RN) #3, the QA Coordinator, on 2/28/17 at 4:15 PM, in the conference room, confirmed the only time that elopements and wanderings had been discussed in QA during the past year was on 1/31/17. This was after Resident #58 eloped from the facility and fell outside, breaking her right arm.	F 620		

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F 520	Continued From page 44 Interview with the Administrator on 3/1/17 at 12:30 PM, in the Administrator's office, confirmed the QA Committee had not identified the elopements as an area to be discussed for development of a QA the QA meeting on 1/31/17. The Immediate Jeopardy was effective from 1/17/17 through 3/1/17. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 3/2/17 and corrective actions were validated through review of documents, observation, and staff interviews. The surveyor verified the allegation of compliance by: 1. Observing the main entrance egress doors for signage of "Notice to Visitors" (not to let residents out of the facility without staff notification), and proper functioning of anti-elopement system on the following doors: A. Main entrance egress doors B. Sun room egress doors C. 400 Hall/Conference room fire exit door D. 500 Hall fire exit door E. 300 Hall fire exit door F. Dining room egress door G. 100/200 Hall ambulance entrance door All egress doors had (1) a 15 seconds delayed magnetic lock with key pad implemented on 2/9/17; (2) a Wanderguard alarm system (If a resident with a Wanderguard bracelet attempted to exit, the doors lock, alarms sound, and the door will not open until the resident with the Wanderguard is removed from the door area). The Wanderguard bracelet was installed and working on 2/21/17.	F 520		

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F 520	Continued From page 45 2. All audible door alarms placed on the Fire and Egress doors continuously emit an audible alarm until the staff respond to the specific alarm and manually deactivate it. 3. Observed the staff response time to all the alarmed doors when triggered by the surveyor on 3/2/17 between 1:05 PM and 1:26 PM. 4. Interviewed 0 visitors on 3/2/17 between 8:00 AM and 12:00 PM, regarding their knowledge about not letting residents out of the building without notifying the nursing staff first, and how to properly sign out a resident from the facility. 5. Reviewed the facility's in-service records to validate the facility staff was in-serviced on the alarm system on the exit doors and the following policies: Wandering and Elopement Wandering, Unsafe Resident 6. Conducted interviews on 3/2/17 with staff to include the Administrator, 8 Registered Nurses, Director of Nursing, 6 Licensed Practical Nurses, 20 Certified Nursing Assistants, 3 Housekeeping and Laundry staff, 4 Dietary staff, 2 Medical Record staff, 1 Maintenance Director, 2 Business Office staff, 2 Rehab staff, and 1 Receptionist, for a total of 50 employees. This was to determine the level of comprehension gained through in-service education regarding the facility's policies, changes to the Wandering and Elopement policy, and implementation of the policy Wandering, Unsafe Resident. Noncompliance continues at a scope and severity of "D" for monitoring the effectiveness of corrective actions and evaluation of monitoring by	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938 0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445190	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HOUSE, THE	250 BELLEBROOK RD BRISTOL, TN 37620

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F 520	Continued From page 46 the Quality Assurance (QA) Committee. The facility is required to submit a plan of correction. Refer to F-278 "J" Refer to F-280 "J" Refer to F-323 "J" Refer to F-353 "J" Refer to F-501 "J"	F 520		